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September 22, 2010

Susan Broetje, Administrator
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **September 17, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00004759

Allegation: The facility failed to provide adequate supervision necessary to keep individuals safe.

Finding: An unannounced on site complaint survey was conducted on 9/16/10 and 9/17/10. During that time a review of facility records, observations, and staff interviews were conducted with the following results:

The facility's "Enhanced Supervision" policy effective 3/18/09, stated individuals required different levels of supervision based on their identified needs as follows:

General Supervision: Staff were to know where individuals were at all times and visually observe the person every 15 minutes.

Arm's Length Supervision: A designated staff was to maintain visual and physical supervision at a distance no greater than 3 feet from the individual and be able to intervene immediately.

Close Proximity Supervision: A designated staff was to maintain visual and physical supervision at a distance no greater than approximately 20 feet and be able to intervene within 10 seconds.

The facility's census report was reviewed on 9/16/10 and documented 53 individuals resided at the facility in 4 separate buildings. On 9/16/10 at 2:20 p.m., the Administrative Support Manager stated there were 6 individuals who required enhanced supervision (arm's length or close proximity).

The facility's incident and accident reports and investigations from 7/21/10 - 9/16/10 were reviewed. Two of the investigations documented 2 individuals had been subjected to neglect, defined as "the failure to provide goods and services necessary to avoid physical harm or mental anguish, including supervision..." per the facility's Abuse Prevention policy effective 6/17/10. The investigations stated the following:

An investigation dated 8/27/10 stated an individual who had a history of harming herself was allowed to have scissors in her possession. The investigation stated the individual was on enhanced supervision. However, when the individual obtained the scissors, she was working with a staff member who had not been formally trained regarding her enhanced supervision guidelines. The investigation documented appropriate corrective action which included ensuring staff were adequately trained prior to being assigned to work with individuals who received enhanced supervision.

An investigation dated 8/31/10 stated an individual who had a history of ingesting inedible objects swallowed a piece of a CD. The investigation stated the individual was on continuous enhanced supervision with periodic room searches. The investigation stated "neglect did occur" as the individual had access to the CD and was able to remove a piece of it. The investigation documented appropriate corrective action which included re-evaluation of the individual's behavior support plan and staff action.

Additionally, A subsequent "Team Investigation and Action Plan," dated 9/10/10, stated "On 8/29 {individual's name} was able to obtain a piece of CD and swallow it. How he was able to get the piece of CD and swallow it when he was on enhanced supervision is being investigated as possible neglect (performance issue) on the part of the staff who was watching {individual's name}. He was taken to the ER {emergency room} and Xray {sic} found nothing." The Plan further stated a follow up appointment was completed and the missing piece of the CD was lodged in the individual's throat and required surgical removal.

The Action Plan documented the individual's behavior support plan had been modified as follows:

- Close proximity supervision was changed to arm's length supervision.
- Body and room search protocols were reviewed and remained unchanged.
- Use of personal items in locked storage was supplemented and clarified and included the locking of the individual's personal possessions, limiting physical contact with his television and playstation to the controller only, limiting the use of his television, CD player and playstation to a central area (not in his bedroom), using a second staff to retrieve the individual's CD player and the CD he requested, disallowing the individual from touching his CD player or CDs and accessing only one CD at a time.
- A lock box for the CD player was to be requested for the CD player when it was not in the secure room.
- The team met on 9/9/10 to develop a medical plan of care to be implemented while the individual was recovering from surgery.
- Re-training of the staff on the individual's behavior support plan and additional safety measures was conducted and to be repeated quarterly or more often as needed.
- Written copies of the behavior support plan, process for keeping the individual safe, and the medical plan of care were placed in a separate document for ready access and required review by staff assigned as the individual's 1:1.
- The behavior support plan was to be reviewed to ensure all steps were clearly documented.

The records of 10 individuals were reviewed. All 10 records specified which level of supervision individuals were to receive. Additionally, observations were conducted on all 4 buildings on 9/16/10 from 12:00 to 12:50 p.m. and from 3:00 to 5:10 p.m. and on 9/17/10 from 7:45 to 9:10 a.m. During those times, individuals were observed to receive supervision as identified in their records.

Throughout the observations conducted on 9/16/10 and 9/17/10, 21 staff were interviewed. All staff could state the level of supervision required for the individuals on the unit they were assigned to. When asked about staff training for individuals requiring enhanced supervision, all staff stated staff were not allowed to work with individuals on enhanced supervision until they were specifically trained to do so.

Staff training records were reviewed from 7/10 - 9/10. The records documented training had been conducted on the individuals' behavior support plans and continued training was scheduled to occur.

It was determined that 2 individuals failed to receive adequate enhanced supervision based on their identified needs, therefore, the complaint is substantiated. However, the facility had identified the failures and implemented appropriate corrective action to minimize the potential for re-occurrence and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm